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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13180

13182

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 134 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 225 BALTIMORE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EFFIE Middle M. Last ABRAHAM		4. DATE OF DEATH Month OCTOBER Day 1 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-87
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (County & State, or foreign country) POUNT SAVAGE, MD.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Head Nurse - County Infirmary Uniontown,		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM HARDEN		14. MOTHER'S MAIDEN NAME LAURA SHAFFER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 172-16-5083	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Cecum (c) Anterior		INTERVAL BETWEEN ONSET AND DEATH 12 mo. 24 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio sclerotic cardio vascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 26, 1966 to Oct 1, 1967 , that (I) (we) last saw the deceased alive on Oct 1, 1967 , and that death occurred at 5:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE DR. DONALD B. GROVE		22b. DATE SIGNED OCT 3, 1967	
22c. PHYSICIAN'S NAME (Type) DR. DONALD B. GROVE		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/4/1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Mariah Baptist Cemetery	23d. LOCATION (City or Town) (County) (State) Smithfield, Penna.
24. FUNERAL DIRECTOR John J. Hager, Jr.		25a. REC'D BY REGISTRAR OCT 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13181

13183

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS Jackson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gilbert Middle R. Last Beeman				4. DATE OF DEATH Month 10/19/1967 Day 19 Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/1904		9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Beeman				14. MOTHER'S MAIDEN NAME Janet Beeman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Robert Beeman, Lonaconing, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 CORONARY OCCLUSION (SON) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Naturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 10/19/1967 22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/22/1967		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR ADDRESS GEORGE EICHHORN Lonaconing, Md. 21539				25a. REC'D BY REGISTRAR OCT 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. MONTH DAY YEAR	
6. SEX		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. KIND OF BUSINESS OR INDUSTRY		14. BIRTHPLACE (County & State, or foreign country)	
15. CITIZEN OF WHAT COUNTRY?		16. FATHER'S NAME		17. MOTHER'S MAIDEN NAME	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		19. SOCIAL SECURITY NO.		20. INFORMANT	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		22. INTERVAL BETWEEN ONSET AND DEATH		23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
27. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		28. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		29. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
30. (City or town)		31. (County)		32. (State)	
33. I certify that (I) (this hospital) attended the deceased from 9/15/67, 19__, to 10/11/67 19__, that (I) (we) saw the deceased alive on 10/10/67 19__, and that death occurred at P. M. from causes and on the date stated above at 1:10 P. M., D.S.T.		34. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		35. DATE SIGNED 10/11/1967	
36. SIGNATURE George M. Simons, M. D.		37. ADDRESS Memorial Hospital, Cumberland, Md.		38. PHYSICIAN'S NAME (Type)	
39. BURIAL, CREMATION, REMOVAL (Specify)		40. DATE THEREOF		41. NAME OF CEMETERY OR CREMATORY	
42. LOCATION (City or Town)		43. (County)		44. (State)	
45. FUNERAL DIRECTOR		46. ADDRESS		47. REC'D BY REGISTRAR	
48. REGISTRAR'S SIGNATURE		DATE		OCT 17 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

D) FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13182

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13185

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>Ridgeley</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>4 Carpenters Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Eugene</u> Last <u>Brant</u>				4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>May 16, 1905</u>	
9. AGE (In years last birthday) yrs. <u>62</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Chief Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Tire Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Ridgeley, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Owen S. Brant</u>				14. MOTHER'S MAIDEN NAME <u>Retta M. Moats</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-07-0163</u>		17. INFORMANT <u>Mrs. Pansy E. Iser</u> Address <u>Ridgeley, W. Va. 4 Carpenters Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock; Exanguination</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Bleeding Duodenal Ulcer</u> DUE TO (c) <u>"</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>5410</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>October 28, 1967</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>			
22. DATE SIGNED							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany, Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u> <u>Cumberland, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 1 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

13182

U.S. DEPARTMENT OF AGRICULTURE

13182

OFFICE OF THE
SECRETARY

WASHINGTON, D. C.
JANUARY 1, 1918

TO THE
MEMBERS OF THE

COMMISSION ON
THE

RECOMMENDATIONS
OF THE

COMMISSION ON
THE

RECOMMENDATIONS
OF THE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13186

FOR STATE
HEALTH DEPT

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1. PLACE OF DEATH a. COUNTY Alleganey MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Alleganey	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY in 1b Life		d. STREET ADDRESS 610 Elm Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.			
3. NAME OF DECEASED (Type or print) Callie		4. DATE OF DEATH Oct. 14, 1967	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1887	
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	
11. BIRTHPLACE (State or foreign country) Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob E. Burns		14. MOTHER'S MAIDEN NAME Mary Gaver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Memorial Hospital		Address Cumberland Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis; Cor Pulmonale DUE TO (c) Emphysema, Bronchiectasis, Silicosis			INTERVAL BETWEEN ONSET AND DEATH Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED October 14, 1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Maryland			
23a. BURIAL, CREMATION, REPOSSSESSION (Specify)	23b. DATE THEREOF Oct. 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Greenmont Cem.	23d. LOCATION (City or town) (County) (State) Cumberland Md.
24. FUNERAL DIRECTOR Louis Stein Inc.		ADDRESS Cumberland Md.	
25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1111

Allegany

Quabbin

Memorial Hosp.

Callic

White

Refined Polymers

Jacob E. Burns

No

None

Memorial Hospital

Quabbin

Acute Cardiac Failure

Chronic Hypertension; Cor Pulmonale

Emphysema, Bronchitis, Atherosclerosis

A

Partial Oct. 17, 1967 Greenback Co.

Quabbin

Partial Oct. 17, 1967

IX October 11, 1967

Quabbin, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 361 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13185

13187

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE ALLEGANY b. COUNTY ALLEGANY MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDLAND, MD. 21542	
c. LENGTH OF STAY in 1b 2 DAYS		d. STREET ADDRESS P. O. BOX #27	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LORETTA Middle L. Last BURNS		4. DATE OF DEATH Month OC T. Day 19 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-31-96
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) ALLEGANY CTY., MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME PATRICK MONAHAN	
14. MOTHER'S MAIDEN NAME GREEN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT HOSP. RECORD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENO-CA, ABDOMINAL, ORIGINAL SITE UNKNOWN 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 MOS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-2-56 , 19__, to 10-19-67 , 19__, that (I) (we) last saw the deceased alive on 10-19-67 , 19__, and that death occurred at __ M, from causes and on the date stated above.			
22a. SIGNATURE R. W. Ballin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) R. W. BALLIN, M. D.		22d. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/23/1967	23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery	23d. LOCATION (City or Town) (County) (State) Frostburg, Md.
24. FUNERAL DIRECTOR EICHORN FUNERAL HOME		25a. REC'D BY REGISTRAR ACT 23 1967	
ADDRESS LONACONING, MD.		25b. REGISTRAR'S SIGNATURE O'Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13188

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Eckhart) R.F.D. 2, BOX 40		
c. LENGTH OF STAY IN 1b lifetime			d. STREET ADDRESS FROSTBURG		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D.2, BOX 40, FROSTBURG					
3. NAME OF DECEASED (Type or print) Anthony Wayne Champ			4. DATE OF DEATH 10 1 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 18, 1967		9. AGE (In years last birthday) 1 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.A.			10b. KIND OF BUSINESS OR INDUSTRY N.A.		11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William Lee Champ		
14. MOTHER'S MAIDEN NAME Catherine McGuire			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N.A.		
16. SOCIAL SECURITY NO. NONE			17. INFORMANT William Lee Champ Eckhart, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7544 ACUTE PULMONARY EDEMA, CARDIAC FAILURE DUE TO AORTIC ENDOTHELIAL FIBROELASTOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGENITAL (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22. DATE SIGNED OCTOBER 1, 1967			23. LOCATION (City or Town) (County) (State) Eckhart Allegany Md.		
24. FUNERAL DIRECTOR HAFFER-SOWERS FUNERAL HOME 60W. Main			25. REGISTRY SIGNATURE Charles Judge		
26. BURIAL, CREMATION, REMOVAL (Specify) Burial			27. DATE THEREOF 10-3-67		
28. NAME OF CEMETERY OR CREMATORY Eckhart Methodist Cemetery			29. LOCATION (City or Town) (County) (State) Eckhart Allegany Md.		
30. FUNERAL DIRECTOR BEULAH H. MONTESANT			31. DATE OCT 5 1967		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #4 Film #G393 10/18/67 ph

13187

CERTIFICATE OF DEATH

13189

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7/17/67	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Cumberland) LaVale		d. STREET ADDRESS Rt. 1, Box 61 B, LaVale, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sophia Middle M. Last Chenowith		4. DATE OF DEATH Month Oct. Day 11 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/1881
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME August Thuss		14. MOTHER'S MAIDEN NAME Christine Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT P.O. Box 599, Cumberland, Md.		18. Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Congestive Heart failure DUE TO (b) Pneumonia DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/17/67 , 19__, to 10/11/67 , 19__, that (I) (we) last saw the deceased alive on 10/11/67 , 19__, and that death occurred at P. M. , from causes and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE SIGNED at 6:25 P. M. 10/12/1967	
22c. PHYSICIAN'S NAME (Type) George M. Simons, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/67	
23c. NAME OF CEMETERY OR CREMATORY Hellens Burial Pl.		23d. LOCATION (City or Town) (County) (State) Cumberland Md	
24. FUNERAL DIRECTOR Louis Stein Inc. - Cumberland Md.		25a. REC'D BY REGISTRAR DATE OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

13119

13119

Allegany

Maryland

Allegany

State

(Cumberland)

7/17/67

Cumberland

Box 1, Box of B. Leavelle, Md.

Allegany County Jail, Maryland

Chenoweth

Sophie

6/19/1881

Female, White

U. S. A.

Maryland

born in

Charles County, Md.

August Thomas

Box 1, Box 2, Cumberland, Md.

Allegany County Jail, Maryland

10/17/67

7/17/67

10/17/67

P. M.

10/17/67

Allegany County Jail, Maryland

George W. Simon, N. D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

13188

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13190

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wilegan y	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monacaoning		c. LENGTH OF STAY IN 1b 1 hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle Nairn Last Cook		4. DATE OF DEATH Month Oct. Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1909
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 01 Days 1	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		12. KIND OF BUSINESS OR INDUSTRY Rail Road	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Arch Cook		16. MOTHER'S MAIDEN NAME Mary Wilson	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		18. SOCIAL SECURITY NO. 220 10 2376	
19. INFORMANT John Cook		20. ADDRESS Westernport, Md.	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH Sudden	
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
26c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		27d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
28e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		29f. (City or town) (County) (State)	
30. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
31. ACTUAL SIGNATURE Benedict Skitarelic		32. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
33. EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		34. DATE SIGNED Oct. 21, 1967	
35. ADDRESS (Street, city, town, or county) Cumberland, Md.		36. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
37b. DATE THEREOF Oct. 25, 1967		38c. NAME OF CEMETERY OR CREMATORY St. Peter's	
39d. LOCATION (City, town or county) (State) Westernport, Md.		40. 24. FUNERAL DIRECTOR Ed Boul	
41. ADDRESS Westernport, Md.		42. 25a. REC'D BY REGISTRAR Charles Judge	
43. 25b. REGISTRAR'S SIGNATURE Charles Judge		44. DATE OCT 21 1967	

1911

1911

James H. Hester



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13189

13191

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.			c. LENGTH OF STAY IN 1b 27 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART					d. STREET ADDRESS 726 OLDTOWN RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MARGARET Ellen D'ALESSANDRO				4. DATE OF DEATH Month OCTOBER Day 28 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-02		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) ALLEGANY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAYMOND TALLEY				14. MOTHER'S MAIDEN NAME GREEN (Barbara)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-8847		17. INFORMANT HOSP. RECORD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>201x</u> <i>Myocardial infarction</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Telegastropicosis</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> , 19 <u>66</u> , to <u>10/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/28</u> 19 <u>67</u> , and that death occurred at <u>10 A M</u> , from causes and on the date stated above.							
22a. SIGNATURE <i>Wayne C. Spiggle</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-28-67	
22c. PHYSICIAN'S NAME (Type) WAYNE C. SPIGGLE, M.D.				22d. ADDRESS 126 N. SMALLWOOD ST. CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 31, 1967		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME				ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE NOV 1 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1311

1310

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

27 DAYS

CUMBERLAND, MD.

725 OLDTOWN RD.

2000000000

25 OCTOBER

11-20-02

01 LESS ANDRO

11-20-02

04

11-20-02

WHITE

FEMALE

U.S.A.

ALLEGANY, MARYLAND

2000000000

HOUSEWIFE

2000000000

BRECH

RAYMOND TALLEY

HOSP. RECORD

214-02-0047

NO

10-28-02

125 E. SHILLWOOD ST. CUMBERLAND, MD.

MARY C. SPAGLE, H.D.

NOV 1 1987

CUMBERLAND, MD.

SCARBELLI FUNERAL HOME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13190

CERTIFICATE OF DEATH

13192

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 23 WASHINGTON ST.	
3. NAME OF DECEASED (Type or print) First Middle Last HUGH DONAHUE		4. DATE OF DEATH Month Day Year OCTOBER 19, 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 19, 1890
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TAVERN KEEPER		10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN DONAHUE		14. MOTHER'S MAIDEN NAME MARY SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-14-5980	
17. INFORMANT MRS. ANGELA WEISENBORNE, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure DUE TO (b) Chronic nephritis DUE TO (c) Rheumatoid arthritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 months - years -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 10, 19 67 to Oct 19, 19 67 that (I) (we) saw the deceased alive on Oct 19, 19 67 , and that death occurred at 11 A.M. from causes and on the date stated above.			
22a. SIGNATURE John B. Davis, M.D.		22b. DATE SIGNED 10/20/67	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.		22d. ADDRESS 5 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR OCT 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1913

1913

1913

13191

CERTIFICATE OF DEATH

13193

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St Marys Terrace		d. STREET ADDRESS St. Marys Terrace	
3. NAME OF DECEASED (Type or print) First Nicholson Middle Eilbeck Last Eilbeck		4. DATE OF DEATH Month 10/9/1967 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/24/1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 74 yrs.
11. BIRTHPLACE (County & State, or foreign country) Pekin, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nicholson Eilbeck		14. MOTHER'S MAIDEN NAME Mary J. Perry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Gertrude Eilbeck Lonaconing, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion (Wife) DUE TO Cardiomegaly Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic C.V. disease DUE TO Arteriosclerotic C.V. disease			INTERVAL BETWEEN ONSET AND DEATH years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Pulmonary fibrosis, emphysema, asthma			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1965 to Oct. 9, 1967 , that (I) (we) last saw the deceased alive on Oct 3 1967 , and that death occurred at 7 P.M. from causes and on the date stated above.			
22a. SIGNATURE L.R. Miles Jr, MD		22b. DATE SIGNED 10.10.67	
22c. PHYSICIAN'S NAME (Type) L.R. MILES JR, MD		22d. ADDRESS LONA CONING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/12/1967	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Moscow, Md.
24. FUNERAL DIRECTOR George Eichhorn Lonaconing, Md.		25a. REGD. BY REGISTRAR OCT 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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2216

1001

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13192

CERTIFICATE OF DEATH

13194

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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 316 GRAND AVENUE,	
3. NAME OF DECEASED (Type or print) First FLOYD Middle R. Last ENGLE		4. DATE OF DEATH Month OCT. Day 22, Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1893
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Watchman		10b. KIND OF BUSINESS OR INDUSTRY Queen Glass Factory	
11. BIRTHPLACE (County & State or foreign country) W. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM ENGLE		14. MOTHER'S MAIDEN NAME RACHAEL FISHELL *CATHERINE FISHELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-1560A	
17. INFORMANT MEMORIAL HOSPITAL- CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Bronchectasis CANDITATIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocarditis & Decompensation (c) 3 weeks			INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 19 7:00 A.M. that (I) (we) lost saw the deceased alive on 19 , and that death occurred at 10/22/67 M, from causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett		22b. DATE SIGNED 10/22/67	
22c. PHYSICIAN'S NAME (Type) DR/ CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/24/1967	23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	23d. LOCATION (City or Town) (County) (State) Frostburg Alleg Md.
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR John J. Hafer, Jr.	
25b. REGISTRAR'S SIGNATURE John J. Hafer, Jr.		DATE OCT 24 1967	

13192

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

FLOYD

MALE WHITE

WILLIAM ENGLE

WILLIAM ENGLE

NO

2 DAYS

CUMBERLAND

310 GRAND AVENUE

OCT. 22

1-1-1933

DR. CLAY E. DUNNETT

U. S. A.

MEMORIAL HOSPITAL - CUMBERLAND, MD.

1-1-1933

13193

CERTIFICATE OF DEATH

MARYLAND

ALLEGANY

OCT. 22

1-1-1933

1-1-1933

DR. CLAY E. DUNNETT

MEMORIAL HOSPITAL - CUMBERLAND, MD.

1-1-1933

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13193

CERTIFICATE OF DEATH

13195

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			c. LENGTH OF STAY IN lb 68yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Charlestown, St.				d. STREET ADDRESS Charlestown, St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN N. GARDNER				4. DATE OF DEATH 10/20/1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/8/1898	
9. AGE (In years last birthday) 68 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William Gardner			
14. MOTHER'S MAIDEN NAME Sarah Jane Gardner				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Margaret Gardner Lonaconing, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO (b) Coronary Insufficiency DUE TO (c) Generalized Atherosclerosis							INTERVAL BETWEEN ONSET AND DEATH hrs. years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic bronchial asthma & emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to Oct 20, 1967 that (I) (we) last saw the deceased alive on Oct. 19, 1967 , and that death occurred at 12 M, from causes and on the date stated above.							
22a. SIGNATURE L.R. Miles Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10.21.67	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.				22d. ADDRESS LONA CONING MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/1967		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Moscow, Md.	
24. FUNERAL DIRECTOR George Eichhorn				ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR Oct 23 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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13132

13132

13132

DET 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

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4

M

13194

13196

13194

CERTIFICATE OF DEATH

13196

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS ROUTE # 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SYLVAN RETREAT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle THOMAS Last GEIGER		4. DATE OF DEATH Month OCTOBER Day 8 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/83
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Uriah M. Geiger		14. MOTHER'S MAIDEN NAME Lydia Knepp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 712-14-1625	
17. INFORMANT Mr. Oklen Geiger, Cumberland, Md.		Address 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 15, 1967 , to Oct. 8, 1967 , that (I) (we) last saw the deceased alive on Oct. 8, 1967 , and that death occurred at 11 P.M. , from causes and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) George M. Simons, M.D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 11, 1967	
23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Gardens La Vale, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE	

2025

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1319'7

13195

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 112 UTAH AVENUE,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.		d. STREET ADDRESS CUMBERLAND, MD.	
3. NAME OF DECEASED (Type or print) First CHARLES Middle Frederick Last GINNIMAN		4. DATE OF DEATH Month OCT Day 9 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-98
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	
11. BIRTHPLACE (County & State, or foreign country) CUMB, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY GINNIMAN		14. MOTHER'S MAIDEN NAME IDA E. Brotherton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL Address Mrs. Edith M. Ginniman 112 Utah Ave.		18. INTERVAL BETWEEN ONSET AND DEATH 3 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO (b) Arteriosclerosis - generalized DUE TO (c) 331X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Squamous carcinoma - left lower leg - amputated June 67			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/4 , 1967 to 10/9 , 1967 that (I) (we) last saw the deceased alive on 10/9 , 1967, and that death occurred at 1:40 P. M, from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Lewis		22b. DATE SIGNED 10/11/67	
22c. PHYSICIAN'S NAME (Type) DR. TIMOTHY LEWIS		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/12/67	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		25. REC'D BY REGISTRAR OCT 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1919

CERTIFICATE OF DEATH

1919

ALLEGANY

WABYLAND

ALLEGANY

CUMBERLAND

2 DAYS

115 UTAH AVENUE

3 ABLELAND, MD.

CHARLES

CHARLES

DEI

MALE

WHITE

11-19-20

DOB

CUMBERLAND, MD.

100 E. BROADWAY

HENRY GINNINSON

CUMBERLAND, MD.

DR. TIMOTHY LEWIS

CUMBERLAND, MD.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13196

CERTIFICATE OF DEATH

13198

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 9 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 202 AVE. M.			
3. NAME OF DECEASED (Type or print) First GEORGE Middle B Last GROVE				4. DATE OF DEATH Month 10 Day 02 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-10-86		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR				10b. KIND OF BUSINESS OR INDUSTRY TEXTILE FACTORY		11. BIRTHPLACE (County & State, or foreign country) GARRETT COUNTY, MD.	
13. FATHER'S NAME NORMAN				14. MOTHER'S MAIDEN NAME SARAH UPHOLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-14-7070		17. INFORMANT Address HOSPITAL RECORD, 200 SETON DR., CUMB., MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive heart failure.							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE Clarence J. Vincent				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/3/67	
22c. PHYSICIAN'S NAME (Type) CLARENCE J. VINCENT, M. D.				22d. ADDRESS 126 N. SMALLWOOD ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 4 '67		23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		23d. LOCATION (City or Town) (County) (State) GARRETT COUNTY, MD.	
24. FUNERAL DIRECTOR ADDRESS DURST FUNERAL HOME, FROSTBURG, MD.				25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13138

ALLEGANY

HARVARD

CUMBERLAND

2 DAYS

CUMBERLAND

SACRED HEART HOSPITAL

202 W. 11

GEORGE

GEORGE

X

WHITE

WHITE

80

10-10-88

JANITOR

TEXTILE FACTORY, GARRETT COUNTY, MD.

US

NORTH

SARAH UPHOLE

MD

210-14-7070

HOSPITAL RECORD, 200 SETON DR. CUM., MD.

FIRST FUNERAL HOME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13197

CERTIFICATE OF DEATH

13199

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and CUMBERLAND)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 209 POTOMAC STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CURTIS Middle A. Last HAWSE		4. DATE OF DEATH Month 10 Day 12 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-15-93 1893
9. AGE (In years birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during 10 years preceding death) RAILROAD WORKER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA Oak		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME ROSS ENOS HAWSE		14. MOTHER'S MAIDEN NAME MOLLY HOKE (Mary)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORD		Address 200 SETON DRIVE, CUMB.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) unk. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-18 , 1967, to 10-12 , 1967, that (I) (we) last saw the deceased alive on 10-12 , 1967, and that death occurred at 10:45 AM, from causes and on the date stated above.			
22a. SIGNATURE <i>J.A. Pagan</i>		22b. DATE SIGNED 10/13/67	
22c. PHYSICIAN'S NAME (Type) J.A. PAGAN, M.D.		22d. ADDRESS 5 POTOMAC ST., RIDGELEY, W.V.A	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-15-1967	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25. REC'D BY REGISTRAR OCT 17 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

13113

13113

ALLEGANY

HARRYBAND

ALLEGANY

CUMBERLAND

22 DAYS

CUMBERLAND

2 /CRED HEART HOSPIT L

209 POTOMAC STREET

CURTIS

A.

HOUSE

10

12

17

WHITE

MALE

02-11-38

74

RAILROAD WORKER

RAILROAD

WEST VIRGINIA

USA

EN22

EN22

HOLLY HOLE

(1938)

NO

HOSPITAL RECORD

200 SETON DRIVE, CUM.

J. L. PUGH, I.D.

2 POTOMAC ST., RIDGELY, W.V.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13195

13200

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN b 12 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. d. STREET ADDRESS 228 BOND ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARVEY C HENDRICKSON		4. DATE OF DEATH Month Day Year OCT 10 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-06
9. AGE (In years lost, birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trimmer		10b. KIND OF BUSINESS OR INDUSTRY Tire	11. BIRTHPLACE (County & State, or foreign country) PA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARVEY HENDRICKSON	
14. MOTHER'S MAIDEN NAME HATTIE BOOR		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-05-5151		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE DUE TO (b) INFERIOR VENA CAVA OBSTRUCTION DUE TO (c) MASSIVE RETROPERITONEAL SARCOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 158X			INTERVAL BETWEEN ONSET AND DEATH 3 weeks 4 weeks 5 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) METASTATIC SARCOMA			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-28-67 to 10-10 , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 3:35 AM , from causes and on the date stated above.			
22a. SIGNATURE Richard E. Schindler		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. RICHARD SCHINDLER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-13-67	23c. NAME OF CEMETERY OR CREMATORY Sun Et Mon. Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.
24. FUNERAL DIRECTOR Robert Kyle Butts Jr. Kitzmiller, Md.		25. REC'D BY REGISTRAR DATE OCT 17 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

13200

13192

ALLSARY
CHURCHLAND
12 DAYS
222 BOND ST.
HERN HERNSON
OCT 10 1947
11-27-00
WHITE
HARVEY HERNHSON
ATTIE BUGH

CHURCHLAND, N.C.
INTERNAL YEAR END REPORT
MEMORIAL HOSPITAL
CHURCHLAND, N.C.
9-27-07
11:30
DR. RICHARD B. BOWMAN
CHURCHLAND, N.C.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13195

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital, DOA				d. STREET ADDRESS 431 Independence St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harold Middle Franklin Last Hershberger				4. DATE OF DEATH Month October Day 31 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-30-21	
9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR Months 4 Days 6		11. IF UNDER 24 HRS. Hours 19 Min. 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman				10b. KIND OF BUSINESS OR INDUSTRY City Fire Dept.		11. BIRTHPLACE (State or foreign country) Holsopple, Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Albert Hershberger				14. MOTHER'S MAIDEN NAME Carrie Helsel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. 220-10-4931		17. INFORMANT Mrs. Helen Hershberger	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Occlusion, Left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Thrombosis, Left DUE TO (c) Coronary Sclerosis, generalized				INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				22. DATE SIGNED XX October 31, 1967			
				Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-3-67		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR H. Lee Silcox				ADDRESS 404 Decatur St, Cumb., Md.		25a. REC'D BY REGISTRAR NOV 3 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

10001

20161

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13200

13202

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 40 McCULLOH STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MABEL Middle E. Last HUSSELBAUGH		4. DATE OF DEATH Month OCTOBER Day 14 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 10, 1925
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES CLERK		10b. KIND OF BUSINESS OR INDUSTRY DEPARTMENT STORE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DENZEL CROWE		14. MOTHER'S MAIDEN NAME ANNA EISLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-20-5062	
17. INFORMANT FRED HUSSELBAUGH, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convulsions DUE TO (b) Cerebral Pressure DUE TO (c) Brain Tumor, probable			INTERVAL BETWEEN ONSET AND DEATH minutes Months ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitaralic M.D.		22. DATE SIGNED October 14, 1967	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 14, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 17 '67	23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE OCT 17 1967	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25b. REGISTRAR'S SIGNATURE Charles Judge	

13.00

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13201

CERTIFICATE OF DEATH

13203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 6 DAYS 17HRS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 15 ALTAMONT TERRACE	
3. NAME OF DECEASED (Type or print) First ARCH Middle JOHNSON Last JOHNSON		4. DATE OF DEATH Month OCTOBER Day 25 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-2-1899
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bartender		10b. KIND OF BUSINESS OR INDUSTRY Brunswick Bar	
11. BIRTHPLACE (County & State, or foreign country) LONA CONING, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DANIEL JOHNSON		14. MOTHER'S MAIDEN NAME JANET CLARK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-03-8606	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1964 to Oct 25 1967 that (I) (we) last saw the deceased alive on Oct 24 1967 and that death occurred at 5:05 AM from causes and on the date stated above.			
22a. SIGNATURE DR. BLANE SCHINDLER		22b. DATE SIGNED 10/25/67	
22c. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER		22d. ADDRESS 43 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/1967	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR OCT 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

13203

CERTIFICATE OF DEATH

13203

ALL COUNTY

6 DAYS 10 HRS

CHICAGO

AT A PLACE

HOSPITAL

1900

AND

ALL WHITE

Entered at Chicago

RECORDED

INDEXED

21-01-1000

20

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13202

CERTIFICATE OF DEATH

13204

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 52 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 23 OFFUTT ST.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle Louis Last KEMP				4. DATE OF DEATH Month OCT Day 9 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-1915		9. AGE (In years lost birthday) 52 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT KEMP				14. MOTHER'S MAIDEN NAME BLANCHE BRIDGE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage 5400 DUE TO (b) Peptic Ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease, Cong. Heart Failure							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/18 19 67 to 10/9 19 67 , that (I) (we) last saw the deceased alive on 10/9 19 67 , and that death occurred at 3:15 P M, from causes and on the date stated above.							
22a. SIGNATURE I. Dross				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/12/67	
22c. PHYSICIAN'S NAME (Type) DR. I. DROSS				22d. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/67		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 16 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

1000

CERTIFICATE OF DEATH

1000

ALLIANCE

MEMORIAL

5 DAYS

CONGREGATION

MEMORIAL

22 OCT 1911

ROBERT

MEMO

OCT

DATE

WHITE

18-1911

ROBERT KEMP

BLANCHE BRIDGES

MEMORIAL

MEMORIAL

1000

DR. J. DRESS

CONGREGATION

WHITE

MEMORIAL

CONGREGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13203

CERTIFICATE OF DEATH

13205

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
c. LENGTH OF STAY IN b 1 DAY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 12 GRANT STREET	
3. NAME OF DECEASED (Type or print) First MARGARET Middle KRAUSE Last KRAUSE		4. DATE OF DEATH Month OCTOBER Day 21 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1883
9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 14 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WILKES BARRE, PENNA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RICHARD HARRIS		14. MOTHER'S MAIDEN NAME ELIZABETH RICHARDS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible shock DUE TO (b) Severe septicaemia DUE TO (c) Peritonitis & G.U. infection		INTERVAL BETWEEN ONSET AND DEATH 74 hrs. 14-16 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/20 , 19 67 , to 10/21 , 19 67 , that (I) (we) last saw the deceased alive on 10/21 , 19 67 , and that death occurred at 9:37 PM causes and on the date stated above.			
22a. SIGNATURE Walter N. Himmler		22b. DATE SIGNED 10/24/67	
22c. PHYSICIAN'S NAME (Type) WALTER HIMMLER, M.D.		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-24-67	23c. NAME OF CEMETERY OR CREMATORY FB'G. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEGANY, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,		25a. REC'D BY REGISTRAR DATE OCT 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1930

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

MARGARET

PEARL WHITE

RICHARD HARRIS

1 DAY

RESTORING

12 GRAND STREET

MARGARET

12-2-1983

WILKES BARRE, PENNA.

ELIZABETH RICHARDS

OCTOBER 21

ALLEGANY

WILKES BARRE

1930

WESTERN PA. OF HEALTH

WESTERN PA. OF HEALTH

1930

WILKES BARRE, PENNA.

WALTER HARRIS, M.D.

1930

WILKES BARRE, PENNA.

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13204

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13206

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 50 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 622 N. CENTRE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA J. Middle LINDNER Last				4. DATE OF DEATH Month OCT. Day 12 Year 19 67			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 15, 1880	
9. AGE (In years last birthday) yrs. 87		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME UNKNOWN			
14. MOTHER'S MAIDEN NAME UNKNOWN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT Address MRS. HARLEY C. WAGONER CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5-4 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) FRACTURE OF RIGHT HIP							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME					
20c. TIME OF INJURY Month, Day, Year Hour 2:30 p.m. 9/18 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) CUMBERLAND ALLEGANY MD.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitaric</i>		EXAMINER'S NAME (Type) BENEDICT SKITARIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED OCT. 12, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 14, 1967		23c. NAME OF CEMETERY OR CREMATORY ST. PETER & PAUL CEMETERY CUMBERLAND, MD.		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT				25a. REC'D BY REGISTRAR DATE OCT 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

10000

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13205

CERTIFICATE OF DEATH

13207

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 34 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 428 FAYETTE STREET	
3. NAME OF DECEASED (Type or print) First ROY Middle C. Last LOTTIG		4. DATE OF DEATH Month 10 Day 10 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-03
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10b. KIND OF BUSINESS OR INDUSTRY COCA-COLA	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY W. Lottig		14. MOTHER'S MAIDEN NAME AGNES (WILLIAMS)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-5238	
17. INFORMANT HOSPITAL RECORD - 200 SETON DRIVE, CUMB.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X uremia with chronic nephritis DUE TO hypertension mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertension C.V. disease DUE TO (c) hypertension C.V. disease		INTERVAL BETWEEN ONSET AND DEATH 3 months year year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1967 to Oct 10, 1967 , that (I) (we) last saw the deceased alive on Sept 10, 1967 , and that death occurred at 12:00 M. from causes and on the date stated above.			
22a. SIGNATURE Blaine Schindler M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) BLAINE SCHINDLER, M.D.		22d. ADDRESS 43 GREENE ST., CUMB., MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/67	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Ph.		23d. LOCATION (City or Town) (County) (State) Cumberland MD	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. MD		25a. REC'D BY REGISTRAR DATE OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

43 GREENE ST., CUM. NO. 21502

BLAINE SCHINDLER, M.D.

HOSPITAL RECORD - 200 SETON DRIVE, CUM.

21-02-223

NO

HENRY

JONES (WILLIAMS)

MANAGER

COO/COL

CUMERLAND, HARLAND

US

WHITE

X

10-1-03

03

ROY

C.

LOTTIG

10

10

7

SACRED HEART HOSPITAL

432 FAYETTE STREET

34 DAYS

CUMERLAND

ALLEGANY

HARLAND

ALLEGANY

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13206

CERTIFICATE OF DEATH

13208

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 3 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 73 HILL STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL			d. STREET ADDRESS FROSTBURG		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NELLIE Middle MAE Last LOVE			4. DATE OF DEATH Month OCTOBER Day 4 Year 19 67		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 7, 1894	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) SHAFT, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOHN ORT		
14. MOTHER'S MAIDEN NAME JEAN CHAPMAN			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N.A.		
16. SOCIAL SECURITY NO. 215-20-6790			17. INFORMANT MRS. LAWRENCE SWEITZER, 73 HILL ST.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage DUE TO 443x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease 20 yr (c)					INTERVAL BETWEEN ONSET AND DEATH 4 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystostomy, Post operative, 8 days.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Sept 12, 1967 , to Sept 5, 1967 , that (I) lost saw the deceased alive on Sept 5, 1967 , and that death occurred at 8:20 PM , from causes and on the date stated above.					
22a. SIGNATURE Alvin J. Walters		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct 6, 1967.	
22c. PHYSICIAN'S NAME (Type) ALVIN J. WALTERS, M.D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 7, 1967		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK	
23d. LOCATION (City or Town) (County) (State) FROSTBURG, MARYLAND					
24. FUNERAL DIRECTOR MARILOU M. SOWERS		25a. REC'D BY REGISTRAR HOME, 60 W. MAIN, FROSTBURG		25b. REGISTRAR'S SIGNATURE Charles Judge	

13308

13308

CERTIFICATE OF DEATH

TO THE PUBLIC

DEATH

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13207

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13209

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 29 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith V Middle Mann Last Mann				4. DATE OF DEATH Month October Day 10 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-17-1879	
9. AGE (In years last birthday) yrs. 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alfred Creek				14. MOTHER'S MAIDEN NAME Rebecca Roberts			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Memorial Hospital-Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Chronic Myocarditis DUE TO (c) ASCV Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 29 Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Comminuted Intertrochanteric Fracture of Left Hip							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell At Home			
20c. TIME OF INJURY Month, Day, Year 12:15 p.m. Sept. 9 19 67				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Little Orleans, Alleg. Md.				20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				22. DATE SIGNED October 10, 1967 Address (Street, city, town, or county) Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF Oct. 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Piney Plaines	
23d. LOCATION (City or Town) Little Orleans, Alleg. Md.				23e. (County) (State)			
24. FUNERAL DIRECTOR Howard J. Grove, Hancock, Maryland				25a. REC'D BY REGISTRAR OCT 16 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge							

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13210

1. PLACE OF DEATH a. COUNTY MIDLAND Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cemetery Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY J. McGee				4. DATE OF DEATH Month 10 / Day 9 / Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug, 25th. 1884 83 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Midland, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Michael Clise				14. MOTHER'S MAIDEN NAME Susan Winters			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lena Tighe Address Midland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO (b) CORONARY SCLEROSIS DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED 10/9/1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/12/1967		23c. NAME OF CEMETERY OR CREMATORY Memorial Park	
24. FUNERAL DIRECTOR GEORGE EICHHOEN				ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE OCT 13 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				23d. LOCATION (City or Town) (County) (State) Frostburg, Md.			

13381

FOR STATE
HEALTH DEPT.

13203

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

-13211

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA SACRED HEART HOSPITAL				d. STREET ADDRESS CRESAP PARK		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALLACE M. McKEE				4. DATE OF DEATH Month OCT. Day 15 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 16, 1884		9. AGE (In years lost birthday) yrs. 83	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER		10b. KIND OF BUSINESS OR INDUSTRY RAYON INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY McKEE				14. MOTHER'S MAIDEN NAME CHARLOTTE McKENZIE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214 07 2958		17. INFORMANT MARY TWIGG		Address CRESAPTOWN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 CORONARY OCCLUSION DUE TO (b) CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH MINUTES
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED October 15, 1967 Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 18, 1967		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG ALLEGANY MD.	
24. FUNERAL DIRECTOR BYRON KIGHT				ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR OCT 17 1967 DATE	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

11/26

1938

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13210

Item #3 Film #G394 11/13/67 ph

CERTIFICATE OF DEATH

-13212

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winchester Rd. Cresaptown, 01-1	
c. LENGTH OF STAY IN 1b 3 DAYS		d. STREET ADDRESS RFD #6, BOX #101 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle ELIZABETH Last McKENZIE		4. DATE OF DEATH Month 10 Day 31 Year 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/20 5-8-20
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (County & State, or foreign country) CRESAPTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT MC KENIZE		14. MOTHER'S MAIDEN NAME ALICE ROBISON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 820-01-4113	
17. INFORMANT HOSPITAL RECORD, 200 SETON DRIVE, CUMB.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage DUE TO (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/28 , 19 67 , to 10/31 , 19 67 , that (I) (we) last saw the deceased alive on 31 Oct 19 67 , and that death occurred at 7:33 PM , from causes on and the date stated above.			
22a. SIGNATURE S. G. WEISMAN		22b. DATE SIGNED 11/1/67	
22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN, MD		22d. ADDRESS 59 GREENE STREET, CUMB., MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/3/67	23c. NAME OF CEMETERY OR CREMATORY St. Ambrose Cemetery	23d. LOCATION (City or Town) (County) (State) Cresaptown, Allegany Md.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		25a. REC'D BY REGISTRAR NOV 6 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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ALLEGANY

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WYOMING

3 DAYS

COUNTDOWN

2. CRED HEART HOSPITAL

REF. NO. BOX 101

10-31-27

MC KENZIE

ELIZABETH

HELLIE

X

WHITE

FEMALE

2-4-20

CRESSAPTOWN, WYOMING

JOHN W. WOOD

HOSPITAL RECORDS

ALICE ROBERTSON

LOBERT MC KENZIE

HOSPITAL RECORD, 200 SETON DRIVE, CUM.

820-01-4113

NO

20 BRIDGE STREET, CUM., WY.

2. G. WEISMAN, JR.

13211

CERTIFICATE OF DEATH

13213

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 27 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 753		
3. NAME OF DECEASED (Type or print) First ROY al Middle CLAY Last MENGES			4. DATE OF DEATH Month OCTOBER Day 14 Year 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-13-1885		9. AGE (In years last birthday) 82 YRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY B&ORR	11. BIRTHPLACE (County & State, or foreign country) HYNDMAN, PA.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME CHARLES D. MENGES			14. MOTHER'S MAIDEN NAME Rebecca R. BEAL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 705-09-2546	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of rectum DUE TO (c) 3 weeks post operative					INTERVAL BETWEEN ONSET AND DEATH 1 week 8 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept. 17, 1967 to Oct 14, 1967 that (I) (we) last saw the deceased alive on 19 and that death occurred at 10:05 P.M. from causes and on the date stated above.					
22a. SIGNATURE FRED W. MILTENBERGER			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) DR. FRED W. MILTENBERGER			22d. ADDRESS CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMAINS	23b. DATE THEREOF Oct. 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery	23d. LOCATION (City or Town) (County) (State) Hyndman, Bedford Co. Pa.		
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Penna.			25a. REC'D BY REGISTRAR OCT 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1931

1931

RECORD

BRANDEY

WINDAN

ALICE

DOUGLAS

VENTRAL HOSPITAL

OCTOBER 14

WELLES

BOY

02

WILE

BORN

WILSON

WELLES, D. BEA

CHAPMAN, D. BEA

NO

Psychological
Observations of

3 months of observation

10:05

WELLES, D. BEA

WELLES, D. BEA

WELLES, D. BEA

WELLES, D. BEA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #11 & 12 Film #G393 10/13/67 ph

13212

CERTIFICATE OF DEATH

13214

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN TB 12/7/63		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Walter Last Miller				4. DATE OF DEATH Month October Day 3 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/1880		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Berkley Spring, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jefferson Miller				14. MOTHER'S MAIDEN NAME Sarah McDonald			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 232-26-3221		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Arterial Insufficiency 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. A.S.H.D. DUE TO arterio sclerosis (c) Senility with cerebral deterioration						INTERVAL BETWEEN ONSET AND DEATH 1 yr. many years many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (q) Senility with cerebral deterioration						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/7/63 , 19__, to 10/3/67 , 19__, that (I) (we) lost saw the deceased alive on 9/30/67 19__, and that death occurred at A. M. from causes on and on the date stated above.							
22a. SIGNATURE John A. Topper				at 5:00 A. M. D.S.T. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/3/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M. D.				22d. ADDRESS Memorial Hospital, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 5, 1967		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Bethel, W. Va.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

13212

Allegany

Allegany

12/1/62

Giddens

Allegany County Jail

James

Walter

Miller

Allegany

67

12/1/62

White

Male

Allegany County Jail

Allegany County Jail

Allegany County Jail

Allegany County Jail

no

12/1/62

12/1/62

12/1/62

John A. Epper, H. D.

Allegany County Jail

Allegany County Jail

Allegany County Jail

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13213

CERTIFICATE OF DEATH

13215

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 yrs., 6 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 01-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SYLVAN RETREAT				d. STREET ADDRESS 109 Maple Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Pearl Last Minnick				4. DATE OF DEATH Month October Day 31 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/28/90		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 11 Days 19	IF UNDER 24 HRS. Hours 19 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland (Montgomery)		12. CITIZEN OF WHAT COUNTRY? U S A U.S.A.	
13. FATHER'S NAME Walter Witt				14. MOTHER'S MAIDEN NAME Mary Shaffer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-0065-D		17. INFORMANT Address Mrs. Mary J. Buckalew, 109 Maple St Frostburg Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Coronary atherosclerosis DUE TO (b) Chc. A.S.H.D. with Hypertension many years. DUE TO (c) arterio-sclerosis many years. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (g) Long-term of L. leg. Senile cerebral degenerative disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 15, 19 67 , to Oct. 31, 1967 , that (I) (we) last saw the deceased alive on Oct. 31 19 67 , and that death occurred at 9 P.M. from causes and on the date stated above.							
22a. SIGNATURE John A. Topper				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-1-67	
22c. PHYSICIAN'S NAME (Type) John A. Topper				22d. ADDRESS Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/ 3/ 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Savage Methodist Cem		23d. LOCATION (City or Town) (County) (State) Mt. Savage, Alleg Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.				ADDRESS 230 Balto Ave. Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 6 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

13212

STATE OF DEATH

13212

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FOR STATE
HEALTH DEPT.

13214

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13216

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital (24 Minutes)</u>		d. STREET ADDRESS <u>115 Harrison St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine -- Moore</u>		4. DATE OF DEATH Month Day Year <u>October 20, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1881</u>
9. AGE (In years last birthday) yrs. <u>86</u>		IF UNDER 1 YEAR Days Hours Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife,</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Don't home</u>	
11. BIRTHPLACE (State or foreign country) <u>Oldtown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? A. <u>U. S. A.</u>	
13. FATHER'S NAME <u>Christopher Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Julia Ann Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No,</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. John R. Kelly</u>		Address <u>727 Maryland Ave. Cumb. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>-----</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>October 20, 1967</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany Md.</u>
24. FUNERAL DIRECTOR <u>H. Wayne George</u> ADDRESS <u>Cumberland, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Memorial Hospital (71 Minutes)

1931

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #8 Film #G394 11/1/67

13215

CERTIFICATE OF DEATH

13217

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN IB 1WK. 3DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 646 N. MECHANIC ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JESSE Middle J. Last MOORE			4. DATE OF DEATH Month OCTOBER Day 26 Year 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 1-28-1884		9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Brewery Worker		11. BIRTHPLACE (County & State, or foreign country) MARYLAND, Lonaconing	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ezekiel J. Moore			
14. MOTHER'S MAIDEN NAME Emily Fazenbaker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 219-03-8054		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Defendant's Appendix with Penetration 550.1 DUE TO Gunshot's antimalaric Penetration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gunshot's antimalaric Penetration (c) Gunshot's antimalaric Penetration INTERVAL BETWEEN ONSET AND DEATH 10 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from June 1960 to Oct 26, 1967 , that (I) (we) last saw the deceased alive on Oct 25, 1967 , and that death occurred at 3:30 AM, at home and on the date stated above.			
22a. SIGNATURE DR. B. SCHINDLER		22b. DATE SIGNED 10/27/67		22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER	
22d. ADDRESS CUMBERLAND, MARYLAND		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 10-28-67		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR OCT 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

10022

ALLEGANY

CONSERVATION

MEMORIAL HOSPITAL

JESSE

MALE WHITE

SEYMOUR

EMERSON E. WHITE

J.

1-28-1933

HARRIS, Pennsylvania

WHITE, Pennsylvania

ALLEGANY

HARRIS

CONSERVATION

648 N. RECHER ST.

OCTOBER 20, 1933

BS

USA

DR. B. SCHINDLER

CONSERVATION, HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>W. Va.</i> b. COUNTY <i>Mineral</i> ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cumberland,</i>				c. LENGTH OF STAY IN lb <i>12 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rt. # 2 Keyser, W. Va.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hosp.</i>						d. STREET ADDRESS <i>Short Gap,</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Joy</i>		Middle <i>Elaine</i>		Last <i>Moreland</i>		4. DATE OF DEATH		Month <i>October</i> Day <i>8,</i> Year <i>1967</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 9, 1949</i>		9. AGE (In years last birthday) <i>18</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Cumberland, Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Arthur C. Moreland</i>						14. MOTHER'S MAIDEN NAME <i>Irene M. Blauch</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No,</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Mr. Arthur C. Moreland Rt. # 2 Keyser, W. Va.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>2892</i> DUE TO (b) <i>CHRONIC GLOMERULONEPHRITIS</i> DUE TO (c) <i>VON GIERKE'S DISEASE---TYPE I</i>										INTERVAL BETWEEN ONSET AND DEATH <i>MONTHS</i> <i>YEARS</i> <i>BIRTH</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>ARTERIOSCLEROSIS</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1954</i> , 19 to <i>PRESENT, 1967</i> , that (I) (we) last saw the deceased alive on <i>OCT 8</i> 19 <i>67</i> , and that death occurred at <i>7:00</i> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>G.O. Himmelwright</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>10-11-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>G.O. HIMMELWRIGHT, MD</i>						22d. ADDRESS <i>133 VIRGINIA AVE, CUMBERLAND, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10/11/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Levels Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Levels, Hampshire, W. Va.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>H. Wayne George Cumberland, Maryland</i>						25a. REC'D BY REGISTRAR <i>OCT 16 1967</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			

MEDICAL CERTIFICATION

18346

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13217

CERTIFICATE OF DEATH

13219

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD., 21502			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 1101 BRADDOCK RD.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MYRTLE Middle S. Last NAZELROD				4. DATE OF DEATH Month OCTOBER Day 16 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-2-84		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) PETERSBURG, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN ALT				14. MOTHER'S MAIDEN NAME SIPHRONE GEORGE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-54-6511		17. INFORMANT HOSP. RECORD Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X <i>myocardial infarction</i> DUE TO (b) <i>arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-14- , 19 67 , to 10-16- , 19 67 , that (I) (we) last saw the deceased alive on 10-15- , 19 67 , and that death occurred at 10-16- , 19 67 , M, from causes and on the date stated above.							
22a. SIGNATURE <i>L. Brings</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <input type="checkbox"/>		22b. DATE SIGNED 10-16-67	
22c. PHYSICIAN'S NAME (Type) DR. LEWIS BRINGS				22d. ADDRESS 57 GREENE ST., CUMB., MD., 21502			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 19, 1967		23c. NAME OF CEMETERY OR CREMATORY Nazelrod Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR William G. Kight				25a. REC'D BY REGISTRAR OCT 23 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	

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U.S.A.

PETERSBURG, W. VA.

HOSPITAL

SIPHONE GEORGE

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HOSP. RECORD

217-21-2211

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27 GREENE ST., CUMBERLAND, MO., 21202

DR. LEWIS BRIDGES

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13218

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13220

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>744 Maryland Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank Shepherd Neff</u>				4. DATE OF DEATH Month Day Year <u>October 24, 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1895</u>	9. AGE (In years last birthday) yrs. <u>72</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. B. Rwy.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George R. Neff</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Bickford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No,</u>		16. SOCIAL SECURITY NO. <u>705-09-9862</u>		17. INFORMANT Address <u>Mrs. Ruth Neff 744 Maryland Ave. Cumb. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Disease--</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>October 24, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hollcrest Burial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany, Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>H. Wayne George Cumberland, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13514

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

VR A15 (4)
25M 1/67

52

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #12 Film #G393 10/23/67									
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 10 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL					d. STREET ADDRESS 44 WRIGHT STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AGATHA Middle NMI Last NICOLATO					4. DATE OF DEATH Month 10 Day 16 Year 1967				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03-10-90		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ITALY			12. CITIZEN OF WHAT COUNTRY? Italy		
13. FATHER'S NAME JEROME BIASI					14. MOTHER'S MAIDEN NAME DOMINICA ARSEGO				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 218-24-8365A		17. INFORMANT HOSPITAL RECORD, 200 SETON DRIVE, CUMB., MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4330 <i>Congestive heart failure.</i> DUE TO (b) <i>atrial fibrillation</i> DUE TO (c) <i>arteriosclerotic Cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.									
22a. SIGNATURE <i>Clarence J. Vincent</i>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/17/67	
22c. PHYSICIAN'S NAME (Type) CLARENCE VINCENT, M.D.						22d. ADDRESS 126 N. SMALLWOOD ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-19-67		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.		
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.				ADDRESS 21532		25a. REC'D BY REGISTRAR OCT 20 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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HOSPITAL RECORD, 200 SETON DRIVE, CUM, IN.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G394 10/30/67 ph

13220

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13222

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital (1 hour)			d. STREET ADDRESS York Hotel, 202 Baltimore Ave.		
3. NAME OF DECEASED (Type or print) First Guy Middle D. Last O'Hara, Jr.			4. DATE OF DEATH Month Oct. Day 23 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Aug. 16, 1921 47 46 yrs.		9. AGE (In years last birthday)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worker		10b. KIND OF BUSINESS OR INDUSTRY Cleaning Estab.		11. BIRTHPLACE (State or foreign country) Gladys, W. Va.	
13. FATHER'S NAME Guy D. O'Hara, Sr.			14. MOTHER'S MAIDEN NAME Nell Clarke		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War II		16. SOCIAL SECURITY NO.		17. INFORMANT Address Sister Mrs. Pauline Holihan, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Skull Fracture DUE TO (Fall from third story) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) " DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from third story window			
20c. TIME OF INJURY Month, Day, Year 11:45 p.m. Oct. 23 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) (County) (State) Cumberland, Alleg. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D. BENEDICT SKITARELIC, M.D.		22. DATE SIGNED October 24, 1967 Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 26, 1967		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR OCT 26 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13221

13223

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 24 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS RT. 1, BOX 448	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle Blaine Last PARSONS		4. DATE OF DEATH Month OCTOBER Day 30 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile	11. BIRTHPLACE (County & State, or foreign country) PARSONS, W.VA.
13. FATHER'S NAME ROBERT PARSONS		14. MOTHER'S MAIDEN NAME BERTIE C. JOHNSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 232-10-9738	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery Disease DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO 10 years (c) Diabetes with Necropneumonia			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1952 to Oct 30, 1967 that (I) (we) last saw the deceased alive on Oct 30, 1967 , and that death occurred on Oct 30, 1967 at 11:50A , from causes on and on the date stated above.			
22a. SIGNATURE B. Blane Schindler		22b. DATE SIGNED Oct 30/67	
22c. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 2, 1967	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City or Town) (County) (State) Parsons, Tucker, W. Va.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

1932

DEPT. OF HEALTH

1932

ALL COPY

MARYLAND

ALLEGANY

CUMBERLAND, MD.

20 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

1, 1, BOX 100

OCTOBER 30

WEDNESDAY

WILLIAM

MALE WHITE

2-17-02

U.S.A.

PARKS, W. VA.

WILLIAM

ROBERT PARKS

BEATTIE C. JOHNSON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

22-1-1-1

CUMBERLAND, MD.

DR. BLAKE SCHMIDT

WILLIAM, PARKS, W. VA.

WILLIAM, PARKS, W. VA.

WILLIAM, PARKS, W. VA.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13222

CERTIFICATE OF DEATH

13224

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 151 HILL ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EVELYN Middle M Last PLUMMER			4. DATE OF DEATH Month OCTOBER Day 19 Year 67		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-10	9. AGE (In years lost birthday) yrs. 57	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) ECKHART, MD.	
13. FATHER'S NAME WILLIAM PAPE			14. MOTHER'S MAIDEN NAME MARY E. HOLSINGER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N.A.		16. SOCIAL SECURITY NO. 220-52-9736		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Diabetes Mellitus DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH 6 yrs 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19__	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumby Alley Md	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 4/7/66 , 19__ 9:40 6/17/67 , 19__, that (I) (we) last saw the deceased alive on 10/12/67 , 19__, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE 		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/21/67	
22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMSLE		22d. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 22, 1967	23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY	23d. LOCATION (City or Town) (County) (State) ECKHART, MARYLAND	25a. REC'D BY REGISTRAR DATE OCT 24 1967	
24. FUNERAL DIRECTOR MARILEU M. SOWERS		25b. REGISTRAR'S SIGNATURE 		HOME, 60 W. MAIN, FROSTBURG	

13023

13023

ALLERBY

ALLERBY

PROSTHESIS

PROSTHESIS

1 DAY

MEMORIAL HOSPITAL

121 HILL ST.

EVERY

FLOWER

OCTOBER

REVALE WIFE

2-5-14

SV

WILLIAM HALE

WILLIAM HALE

MEMORIAL HOSPITAL, CIVIL AND MILITARY

DR. R. O. WIERMAN

CHIEF, CIVIL AND MILITARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13223

CERTIFICATE OF DEATH

13225

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2½ DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 101 GREENE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EUGENIA Middle Hortense Last POLING			4. DATE OF DEATH Month OCTOBER Day 8 Year 19 67		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-1876		9. AGE (In years lost birthday) 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Greenspring, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME JOHN P. Ullum		
14. MOTHER'S MAIDEN NAME SUSAN WARD			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis (c) Generalized Atherosclerosis					INTERVAL BETWEEN ONSET AND DEATH 1-27-67 10-22-67
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.	
20f. (City or town) (County) (State) Cumberland, Md.		21. I certify that (I) (this hospital) attended the deceased from 7/7/62 , 19____ to 10/8/67 , 19____ that (I) (we) last saw the deceased alive on 10/7/67 , 19____, and that death occurred at 12:45 A.M. on 10/8/67 from causes and on the date stated above.			
22a. SIGNATURE DR. R.J. WILLIAMS			22b. DATE SIGNED 10/8/67		22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS
22d. ADDRESS CUMBERLAND, MARYLAND			22e. ADDRESS CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.		24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.			
25a. REC'D BY REGISTRAR OCT 16 1967			25b. REGISTRAR'S SIGNATURE James J. Jones		

1932

DEATH OF DEATH

1932

ALLEGANY

CUMBERLAND

SIX DAYS

MEMORIAL HOSPITAL

101 GREENE STREET

BOILING

OCTOBER

10-24-1875

DO

MEMORIAL HOSPITAL

JOHN W. LUTHER

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. R. J. WILLIAMS

CUMBERLAND, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13224					13226						
Item #9 Film #G393 10/23/67											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Barton					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Barton						
c. LENGTH OF STAY IN 1b 55 Yrs					d. STREET ADDRESS 01-1						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Ray			First Alton Middle Preston Last			4. DATE OF DEATH Oct. 17 1967			Month 17 Day 1967		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1910		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 05 Days 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Roofing		11. BIRTHPLACE (County & State, or foreign country) Allegany-Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Preston					14. MOTHER'S MAIDEN NAME Amy Metz						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 417-05-0773			17. INFORMANT Alta Preston-Barton, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Coronary Insufficiency DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus									INTERVAL BETWEEN ONSET AND DEATH minutes 2 years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Oct 12, 1967 to Oct 12, 1967 , that (I) (we) last saw the deceased alive on Oct 16, 1967 , and that death occurred at 11 PM , from the causes and on the date stated above.											
22a. SIGNATURE Leslie Miles					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10-18-67			
22c. PHYSICIAN'S NAME (Type) Leslie Miles					22d. ADDRESS Lonaconing, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/20/67		23c. NAME OF CEMETERY OR CREMATORY Salisbury			23d. LOCATION (City, town or county) (State) Salisbury Pa.			
24. FUNERAL DIRECTOR Westernport, Md.					25a. REC'D BY REGISTRAR OCT 20 1967					25b. REGISTRAR'S SIGNATURE Charles Judge	

13330

13330

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "consider" and "and" are faintly visible.]

13225

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13227

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 34 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 117 W. MAIN ST.	
3. NAME OF DECEASED (Type or print) EMMA First Middle Last		4. DATE OF DEATH OCTOBER 10, 1967 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 1, 1882
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS EVANS		14. MOTHER'S MAIDEN NAME MARY A. LANGFORD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-6485A	
17. INFORMANT PERCY E. RACE, FROSTBURG, MD. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of Bowel DUE TO (b) Mesenteric Thrombosis DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 3-4 days 3-4 days —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of left humerus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarellic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) RD9, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 12, 1967	
23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR DATE OCT 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

The following information is being provided for your information and is not intended to be used for any other purpose. The information is being provided for your information and is not intended to be used for any other purpose. The information is being provided for your information and is not intended to be used for any other purpose.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13226

13228

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 3 DAYS		d. STREET ADDRESS 572 MC MULLEN HIGHWAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELMER MARSHALL ROBOSSON		4. DATE OF DEATH Month Day Year OCT. 8, 19 67.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-1919
9. AGE (In years last birthday) yrs. 47		10. IF UNDER 1 YEAR Months Days Hours Min. 9 months	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee- Kelly Springfield Tire Co.		11b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME THOMAS P. ROBOSSON		14. MOTHER'S MAIDEN NAME ANNA R. ROBINETTE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-10-5911	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastases to the brain (c) 9 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 67	21b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10-5	21d. (City or town) (County) (State) 10-8 19 67
21. I certify that (I) (this hospital) attended the deceased from 10-5 , 19 67 , to 10-8 , 19 67 , that (I) (we) last saw the deceased alive on 10-7 , 19 67 , and that death occurred at 7:25 A.M. on 10-8 , 19 67 , and on the date stated above.			
22a. SIGNATURE Dr. I. Dross		22b. DATE SIGNED 10/9/67	
22c. PHYSICIAN'S NAME (Type) DR. I. DROSS		22d. ADDRESS 456 N. CENTRE ST. CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/11/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland, Maryland 21502		25a. REC'D BY REGISTRAR OCT 11 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1932

TEST OF DEATH

1932

ALLEGANY

MARYLAND

ALLEGANY

3 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

572 MC NULTEN HIGHWAY

ELMER

ROBSON

OCT.

87

MALE WHITE

11-14-1919

MARYLAND

U.S.A.

THOMAS P. ROBSON

ANNA R. ROBINETTE

MEMORIAL HOSPITAL - CUMBERLAND, MD.

DR. J. DROSS

456 N. CENTRE ST.

CUMBERLAND

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13227

13229

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 30 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. 01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 102 HILLCREST RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESTHER Middle C Last RUNYAN				4. DATE OF DEATH Month OCT Day 10 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-23		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) PITTS, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LIVINGSTONE CHARLES R. XXXXX				14. MOTHER'S MAIDEN NAME HOLZWORTH VIRGINIA HOLZWORTH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO. 185-12-7412		17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liposarcoma - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary in kidney fat - DUE TO (c) Generalized metastasis						INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-10-67 , 19 67 , to 10/10/67 , that (I) (we) last saw the deceased alive on 10/10/67 , 19 67 , and that death occurred at 5:50 AM , from causes and on the date stated above.							
22a. SIGNATURE Thomas F. Lusby				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/12/67	
22c. PHYSICIAN'S NAME (Type) DR. THOMAS F. LUSBY				22d. ADDRESS LA VALE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/1967		23c. NAME OF CEMETERY OR CREMATORY Winchester National Cem.		23d. LOCATION (City or Town) (County) (State) Winchester Frederick Va	
24. FUNERAL DIRECTOR John J. Hafer, Jr.				25a. REC'D BY REGISTRAR DCT 13 1967		25b. REGISTRAR'S SIGNATURE John J. Hafer, Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1938

1938

CLINICAL RECORD

ALLEGANY

MARYLAND

WEST VIRGINIA

CUMBERLAND

30 DAYS

CUMBERLAND, MD.

MEMORIAL HOSPITAL

30 HILLCREST RD.

ASTHMA

BUNYAN

001

FEMALE WHITE

8-11-33

41

LIVINGSTONE
CHARLES R. LIVINGSTONE

VIRGINIA HOSPITAL

CUMBERLAND, MD.

MEMORIAL HOSPITAL

DR. THOMAS F. LUSBY

LA VILLE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13230

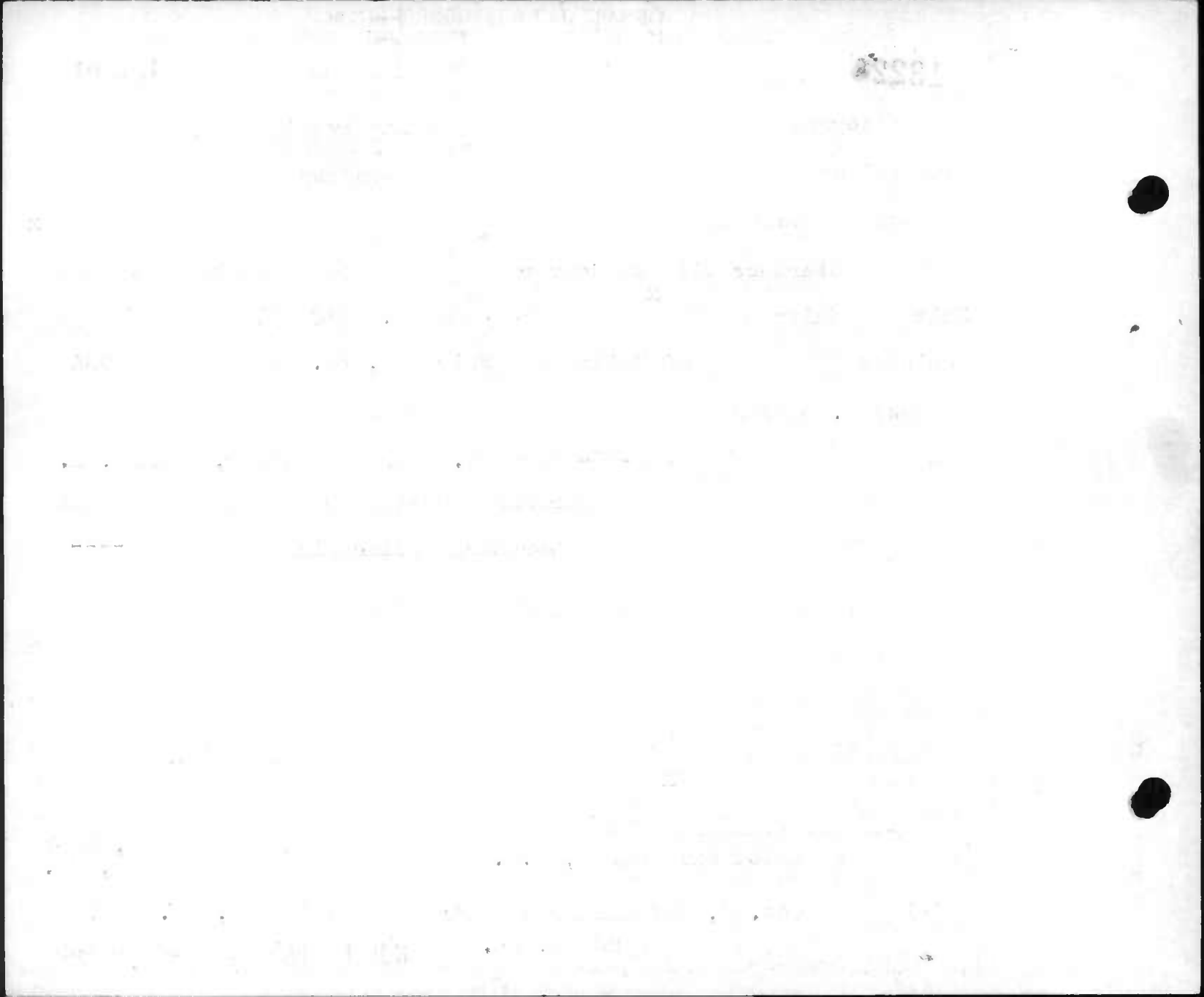
FOR STATE
HEALTH DEPT.

13228

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Bedford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyndman			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS			75-3
3. NAME OF DECEASED (Type or print) First Middle Last Clarence William Sarver				4. DATE OF DEATH Month Day Year October 25, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 16, 1910		9. AGE (In years last birthday) yrs. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) Fairhope, Pa. RD#1		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ross M. Sarver				14. MOTHER'S MAIDEN NAME Ivana Miller Sarver			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 209-09-1769		17. INFORMANT Address Mrs. Clarence Sarver, Hyndman, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Sclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Sudden -----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED October 25, 1967 Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Miller Cemetery		23d. LOCATION (City or Town) (County) (State) Fairhope, Pa. RD#1	
24. FUNERAL DIRECTOR <i>Harvey W. Zeigler</i>		ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR DATE NOV 1 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
13229									
13231									
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 58 WEMPE DRIVE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOMER Middle N Last SELLERS					4. DATE OF DEATH Month OCTOBER Day 18 Year 67				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-31-91		9. AGE (In years last birthday) 75-76 rs.	
						IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter			10b. KIND OF BUSINESS OR INDUSTRY Textile		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES A. SELLERS					14. MOTHER'S MAIDEN NAME KATHERINE MANDEL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War I			16. SOCIAL SECURITY NO. 217-10-5343		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Prostate DUE TO (c) Coronary Heart Disease								INTERVAL BETWEEN ONSET AND DEATH 15 min 4 hrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 18, 1967 to Oct 18, 1967 that (I) (we) last saw the deceased alive on Oct 18, 1967 , and that death occurred at 6:40 P.M. from causes and on the date stated above.									
22a. SIGNATURE Clay Durrett M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/19/67		
22c. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT					22d. ADDRESS CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct. 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR DATE OCT 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

13323

13323

ALL EARS

MARYLAND

ALL EARS

CUMBERLAND

DATE

CUMBERLAND

30 WEMPE DRIVE

MEMORIAL HOSPITAL

SELLERS - OCTOBER 10

ROVER

10-11-51

MALE WHITE

CUMBERLAND, MARYLAND

Textile

Textile

CATERER - HONOLULU

CHARLES A. SELLERS

SIX-ONE AND MEMORIAL HOSPITAL, CUMBERLAND, MD.

Hand

For

[Faint, illegible handwritten notes and signatures]

CUMBERLAND, MD.

DR. CLAY DORRITT

[Faint, illegible text at the bottom of the page]

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13230

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13232

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. STREET ADDRESS <u>833 Columbia Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Arley</u> Middle <u>Delbert</u> Last <u>Sherman</u>		4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 21, 1889</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. boilermaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. Rwy.</u>	
11. BIRTHPLACE (State or foreign country) <u>Barbour Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William E. Sherman</u>		14. MOTHER'S MAIDEN NAME <u>Catharine Bolyard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-12-4708</u>	
17. INFORMANT <u>Mrs. Gilbert Markwood</u>		Address <u>Cumb. Md. 833 Columbia Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> stating the underlying cause lost. (c) <u>Years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/2/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	
25a. REC'D BY REGISTRAR DATE <u>NOV 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18

<div>13231</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>13233</div>											
1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 36 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL						d. STREET ADDRESS 133 1/2 N. CENTRE STREET					
3. NAME OF DECEASED (Type or print) First Middle Last DELICIE S. SMITH						4. DATE OF DEATH Month Day Year 10 17 67					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-2-09		9. AGE (In years last birthday) yrs. 58		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.		11. BIRTHPLACE (County & State, or foreign country) ELK GARDEN, W.VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES H. SOLLARS						14. MOTHER'S MAIDEN NAME ELIZABETH (MURPHY)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-03-8787		17. INFORMANT SACRED HEART HOSPITAL HOSPITAL RECORD- 900 SETON DRIVE, CUMB., MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATO-RENAL FAILURE DUE TO (b) METASTASIS OF CARCINOMA DUE TO (c) CARCINOMA OF STOMACH ADVANCED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. SEVERAL MONTHS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-6-67 , 19 67 , to 10-17 , 19 67 , that (I) (we) last saw the deceased alive on 10-16-1967 , and that death occurred at 1 M, from causes and on the date stated above.											
22a. SIGNATURE Richard Schindler M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED OCT 20-1967	
22c. PHYSICIAN'S NAME (Type) DR. R. SCHINDLER						22d. ADDRESS 69 GREENE ST., CUMB., MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-19-67		23c. NAME OF CEMETERY OR CREMATORY Hartmansville Family				23d. LOCATION (City or Town) (County) (State) TRD Elk Garden Mineral W.Va.			
24. FUNERAL DIRECTOR PRITTS FUNERAL HOME, KITZMILLER, MARYLAND						25a. REC'D BY REGISTRAR DATE OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

PRITZ-FUNERAL HOME, KITZILLER, MARYLAND

DR. R. SCHINDLER

30 GREENE ST., CUM., MD. 21202

NO

210-03-287

HOSPITAL RECORD-000 SETON DRIVE, CUM., MD.

JAMES H. SOLLARS

ELIZABETH (MURPHY)

MACHINE OPERATOR

CELPHESSE CORP.

ELK GARDEN, W. VA.

U.S.A.

FEMALE

WHITE

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10-2-03

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DELICIE

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SACRED HEART HOSPITAL

133 1/2 N. CENTRE STREET

CUMBERLAND

30 DAYS

CUMBERLAND

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18223

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24-hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72-hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13232

CERTIFICATE OF DEATH

13234

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12/2/1963	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 147 Polk Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Margaret Last Smith		4. DATE OF DEATH Month October Day 23 , Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/1887
9. AGE (In years last birthday) yrs. 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Presser-Sanford Cleaning Establishment		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Twigg		14. MOTHER'S MAIDEN NAME Martha Ellen Pittman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-6985	
17. INFORMANT P.O. Box 599, Cumberland, Md. 21502		18. ALLEGANY COUNTY INFIRMARY RECORDS.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebro-vascular accident DUE TO (b) Acute C.V.A. - Hemiplegia, Rt. DUE TO (c) Arterio-Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Arterio Sclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/2/63 , 19__, to 10/23/67 , 19__, that (I) (we) last saw the deceased alive on 10/23/67 , 19__, and that death occurred at P. M. , from causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED 10/24/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md	
24. FUNERAL DIRECTOR John J. Nafer, Jr.		25. REC'D BY REGISTRAR OCT 27 1967	
26. ADDRESS 230 Balto Ave., Cumberland		27. REGISTRAR'S SIGNATURE Charles Judge	

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STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove columns 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13233

CERTIFICATE OF DEATH

13235

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB 6/9/1965	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 106 Decatur Street	
3. NAME OF DECEASED (Type or print) First Ida Middle Myrtle Last Steele		4. DATE OF DEATH Month October Day 18 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/1883
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland Saxton, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob College		14. MOTHER'S MAIDEN NAME Margaret McLane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599, Cumberland, Md.		18. Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Myocarditis DUE TO Gen. Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/9/1965 , 19 67 , to 10/18/1967 , that (I) (we) last saw the deceased alive on 10/17/67 , 19 67 , and that death occurred at P. M. from causes and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE SIGNED at 4:00 A.M., D.S.T. 10/18/1967	
22c. PHYSICIAN'S NAME (Type) George M. Simons, M. D.		22d. ADDRESS Memorial Hospital, Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/20/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR DATE OCT 23 1967	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

13230

13230

Allegany

Allegany

Allegany

6/9/1955

6/9/1955

6/9/1955

100 West 3rd Street

Allegany County Jail

10

October 11

State

State

State

84

6/11/1955

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White

White

Allegany County Jail

Allegany County Jail

Allegany County Jail

Allegany County Jail
P.O. Box 500, Cumberland, Md.
21502

Allegany County Jail

6/9/1955

6/9/1955

6/9/1955

Allegany County Jail

6/9/1955

Allegany County Jail

George M. Simon, M.D.

Allegany County Jail

Allegany County Jail

Allegany County Jail

Allegany County Jail

Allegany County Jail

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13234

CERTIFICATE OF DEATH

13236

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN TB 11 HRS. 30 MIN.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 402 SOUTH ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BESSIE Middle P Last STEWART				4. DATE OF DEATH Month OCTOBER Day 25 Year 67			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-9-90	
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA-Timberville		12. CITIZEN OF WHAT U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA-Timberville	
13. FATHER'S NAME WILLIAM H. MILLER				14. MOTHER'S MAIDEN NAME JANE TURNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-vascular Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture right Hip---Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1954 , 19 10:40 P.M. , 19 67 , that (I) (we) last saw the deceased alive on October 25, 67 , and that death occurred at 10:40 P.M. , 19 67 , from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct. 27, 1967	
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT				22d. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 30 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

13234

13234

ALL DAY

ALL DAY

CUMBERLAND

CUMBERLAND

11 WTS. 30 WTS.

EMERSONIAL HOSPITAL

402 SOUTH ST.

RECEIVED

OCTOBER 25

10-2-30

RECEIVED WHITE

VIRGINIA

LOWE

JANE TURNER

WILLIAM L. MILLER

EMERSONIAL HOSPITAL, CUMBERLAND, MD.

no

EMERSONIAL HOSPITAL, CUMBERLAND, MD.

EMERSONIAL HOSPITAL, CUMBERLAND, MD.

EMERSONIAL HOSPITAL, CUMBERLAND, MD.

10:00 AM

10:00 AM

10:00 AM

CUMBERLAND, MD.

DR. J. D. HENDERSON

10:00 AM

10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13235

13237

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 60 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 168 WEST MAIN STREET		d. STREET ADDRESS 168 WEST MAIN STREET	
3. NAME OF DECEASED (Type or print) JULIA TACCINO		4. DATE OF DEATH Month OCTOBER Day 29 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 24, 1891
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) PROVINCE OF SPEZZANO, COSANZO, ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL GIVIGLIANO		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. N.A.	
17. INFORMANT MRS. VERA PIFALO		Address FROSTBURG, MARYLAND 174 WEST MAIN STREET	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDIAL FAILURE DUE TO (b) CHRONIC ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 6 mos.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/27, 19 67 , to 10/29, 19 67 , that (I) (we) last saw the deceased alive on 10/29, 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED 10/30/67	
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M.D.		22d. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 2, 1967	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MARYLAND	
24. FUNERAL DIRECTOR Marion M. Sowers		25a. REC'D BY REGISTRAR NOV 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Chronic Myocardial Failure
Chronic Arteriosclerosis (Heart Disease)

10/24/33

P. R. Thompson

X

10/24/33

10/24/33

Nov 3 1933

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13236

CERTIFICATE OF DEATH

13238

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA	
c. LENGTH OF STAY IN TB 26 DAYS		d. STREET ADDRESS 2327 DUKE ST., APT. E33	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JANET H. TEDDER		4. DATE OF DEATH Month Day Year OCTOBER 4 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-38
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASST. TRAVEL DIRECTOR		10b. KIND OF BUSINESS OR INDUSTRY TRAVEL AGENCY	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD., ALLEGANY		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME STANLEY HANNA		14. MOTHER'S MAIDEN NAME MADGE LIGHT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 234 58 1501	
17. INFORMANT HOSP. RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUPUS NEPHRITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LUPUS ERYTHEMATOSIS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-8, 19 67 , to 10-4, 19 67 , that (I) (we) last saw the deceased alive on 10-4 19 67 , and that death occurred at 8:30 AM , from causes and on the date stated above.			
22a. SIGNATURE L. Michael Gluck		22b. DATE SIGNED 10-5-67	
22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLUCK		22d. ADDRESS 126 N. SMALLWOOD ST	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/7/67	23c. NAME OF CEMETERY OR CREMATORY Philos Cem.	23d. LOCATION (City or town) (County) (State) Westernport, Md.
24. FUNERAL DIRECTOR BOAL'S FUNERAL HOME		25a. REC'D BY REGISTRAR DCT 9 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13286

ALLCOY

CUMBERLAND

RECEIVED HEART HOSPITAL

JANET

FEMALE WHITE

ASST. TRAVEL OFFICE, TRAVEL AGENCY

STANLEY HANNA

NO

VIRGINIA

ALEXANDRIA

26 DAYS

3037 DUKE ST., APT. 733

LEADER

HI

7-26-22

CUMBERLAND, MD., ALLCOY

HOTEL, BIRMINGHAM

111 CHURCH ST.

DEPT. OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

13237

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13239

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SAC RED HEART HOSPITAL		d. STREET ADDRESS 654 NATIONAL HIGHWAY	
3. NAME OF DECEASED (Type or print) First FRANCESCA Middle H. Last TEPPER		4. DATE OF DEATH Month OCTOBER Day 5 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-28-03
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) PHILADELPHIA, PENNA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES E. HANNA		14. MOTHER'S MAIDEN NAME Frances DUFRESNE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. HOSP. RECORD	
17. INFORMANT HOSP. RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Rupture + Tamponade 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic + Coronary Art Dis DUE TO (c) Fewer		INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Adenoca of Ascending Colon		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-12 , 1967, to 10-5 , 1967, that (I) (we) last saw the deceased alive on 10-5 1967, and that death occurred at 7:30PM , from causes on and on the date stated above.			
22a. SIGNATURE A. J. Mirkin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. A. J. MIRKIN		22d. ADDRESS 115 So. Centre - Cumberland, MD.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 10/9/67	
23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Garden		23d. LOCATION (City or Town) (County) (State) Cumberland MD.	
24. FUNERAL DIRECTOR LOUIS STEIN, INC.		25a. REC'D BY REGISTRAR OCT 11 1967	
117 FREDERICK ST. CUMBERLAND, MD. 21502		25b. REGISTRAR'S SIGNATURE Charles Judge	

1323

ALLEGANY

WYOMING

CUMBERLAND

CUMBERLAND

SOC RED HEART HOSPITAL

25th NATIONAL HIGHWAY

FINA CESSA

TEPPER

OCTOBER

X

FEMALE WHITE

03-28-03

4

HOUSEWIFE

PHILADELPHIA, PENN.

U. S. A.

JAMES E. HANNA

DURESSIE

NO

HOSP. RECORD

10-12

300

117 FREDERICK ST.
CUMBERLAND, MD. 21202

LOUIS STELL, INC.

1521 S. 17th ST., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13238					13240				
1. PLACE OF DEATH a. COUNTY <u>Allegany</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Luke</u>			c. LENGTH OF STAY IN 1b <u>46 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Luke</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>89 Mullen Ave.</u>					d. STREET ADDRESS <u>89 Mullen</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Manuel Quiros Tuya</u>			First Middle Last		4. DATE OF DEATH <u>Oct. 15 19 67</u>		Month Day Year		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1, 1894</u>		9. AGE (In years last birthday) <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Spain</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alvaro Quiros</u>					14. MOTHER'S MAIDEN NAME <u>Carmen Tuya</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>214 32 3048</u>		17. INFORMANT <u>Gloria Tuya Dunn, Reese, Mich.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>584x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sequella of operation for cholelithiasis.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u> <u>4 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 5</u> , 19 <u>67</u> , to <u>10/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct. 15</u> , 19 <u>67</u> , and that death occurred at <u>5.30p</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>James Wolverton Sr.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/16/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>James Wolverton Sr. M.D.</u>					22d. ADDRESS <u>Green St. Piedmont, W. Va.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			23b. DATE THEREOF <u>10/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>		23d. LOCATION (City, town or county) (State) <u>Westernport, Md.</u>		
24. FUNERAL DIRECTOR <u>E. B. B...</u>					ADDRESS <u>Westernport, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>		
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

13340

13341

Summary of operation for classification

Oct 13 1961

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13238

CERTIFICATE OF DEATH

13241

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE		c. LENGTH OF STAY IN 1b 40 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 422 NATIONAL HIGHWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUSSELL S. WAGNER		4. DATE OF DEATH Month OCT. Day 6 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 15, 1906
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10b. KIND OF BUSINESS OR INDUSTRY BANKING	
11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PETER H. WAGNER		14. MOTHER'S MAIDEN NAME MARGARET SHERRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO. 217 14 4151	
17. INFORMANT MRS. DOROTHY WAGNER		Address LA VALE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastases DUE TO (b) Bronchogenic Carcinoma stating the underlying cause last. (c) Interval between ONSET AND DEATH 3 mo 13 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/6 , 19 66 , to 10/6 , 19 67 , that (I) (we) last saw the deceased alive on 10/6 , 19 67 , and that death occurred at 9 P.M. , from causes and on the date stated above.			
22a. SIGNATURE R. Rhett Rathbone		22b. DATE SIGNED OCT. 7, 1967	
22c. PHYSICIAN'S NAME (Type) R. RHETT RATHBONE, M.D.		22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 9, 1967	23c. NAME OF CEMETERY OR CREMATORY REST LAWN MEM. GARDENS	23d. LOCATION (City or Town) (County) (State) CUMBERLAND MARYLAND
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR OCT 10 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6852

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13240

CERTIFICATE OF DEATH

13242

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 65 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		d. STREET ADDRESS 852 CAMDEN AVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RALPH Middle R Last WEBSTER		4. DATE OF DEATH Month OCT. Day 2 Year 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-01
9. AGE (In years lost day) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Sup't		10b. KIND OF BUSINESS OR INDUSTRY Allegany County	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LENNIE WEBSTER		14. MOTHER'S MAIDEN NAME ISADORA DANIEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-16-2042	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undifferentiated Carcinoma Bladder DUE TO (b) Generalized metastases to bones DUE TO (c) 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 8 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1 Dec. 63 to 2 Oct 1967 that (I) (we) last saw the deceased alive on 1 Oct. 1967 , and that death occurred at 9:45A M, from causes and on the date stated above.			
22a. SIGNATURE W. A. Van Ormer		22b. DATE SIGNED 2 Oct. 67	
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/4/1967	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md.
24. FUNERAL DIRECTOR John J. Haier, Jr.		25a. REC'D BY REGISTRAR NOV 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1934

1934

DEPARTMENT OF HEALTH

ALLEGANY

WARRAND

ALLEGANY

COMBERLAND, MD.

62 DAYS

COMBERLAND

843 CAMDEN AVE

MEMORIAL HOSPITAL

WEBSTER

RALPH

MALE WHITE

11-18-01

MEMORIAL HOSPITAL

WEBSTER

1934

COMBERLAND, MD.

CP. W. A. VAN ORVER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13241

13243

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			d. STREET ADDRESS ROUTE #1 BOX 127		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last VIRGINIA SAYVILLE WHITE			4. DATE OF DEATH Month Day Year OCTOBER 21 19 67		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-31-15		9. AGE (In years lost birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ALLEGANY CTY., MARYLAND	
13. FATHER'S NAME COLUMBUS MILLER			14. MOTHER'S MAIDEN NAME WM WHITTINGTON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-26-9975		17. INFORMANT HOSP. RECORD Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH unk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Anemia					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/18, 1967 , to 10/21, 1967 , that (I) (we) last saw the deceased alive on 10/21 1967 , and that death occurred 10/21 PM , from causes and on the date stated above.					
22a. SIGNATURE J. A. Pagan, M.D.			22b. DATE SIGNED 10/23/67		22c. PHYSICIAN'S NAME (Type) J. A. Pagan, M.D.
22d. ADDRESS 5 POTOMAC ST., RIDGELEY, W. VA.			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/25/67	23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City or Town) (County) (State) Westernport Md.
24. FUNERAL DIRECTOR ELLSWORTH BOAL			25a. REC'D BY REGISTRAR OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

1324

1324

ALLEGANY	WESTERNPORT, MD.	ALLIED
CUMBERLAND	3 DAYS	WESTERNPORT, MD.
SACRED HEART HOSPITAL	ROUTE #1 BOX 127	X
IRISHIA	WHITE	OCTOBER 21
X	12-31-12	27
FEMALE	WHITE	21
HOUSEWIFE	ALLEGANY CTY, MARYLAND	20
COLUMBUS MILLER	WHITTINGTON	
NO	212-26-0725	
	HOSP. RECORD	

J. I. P. B. 1. D. 2 PHOTO ST. RIDGELY, I. M.

WESTERNPORT, MD. 1324

1334

1334

CERTIFICATE OF DEATH

ALLGANY

MARYLAND

ALLGANY

CUMBERLAND (PRINCE)

2 DAYS 23HR

CUMBERLAND

RT. 2, DEHAVEN ROAD

MEMORIAL HOSPITAL

OCTOBER 2, 1907

W. WILLIAMS

CHARLES

WHITE

1892-1907

USA

CUMBERLAND, MARYLAND

LIQUOR STORE

DINNER

CLARA WILKINSON

CHARLES H. WILKINSON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

CUMBERLAND, MARYLAND

DR. W. F. WILLIAMS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13243

13245

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PIEDMONT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 3HR 25 MIN.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIEDMONT		d. STREET ADDRESS 26 GREEN STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GERALDINE L. WILKINSON		4. DATE OF DEATH Month Day Year OCTOBER 20 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MARCH 5, 1926
9. AGE (In years last, birthday) 41 yrs.		10. IF UNDER 1 Year Months Days Hours Min. 41 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (County & State, or foreign country) MORGANTOWN, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES P. WILKINSON		14. MOTHER'S MAIDEN NAME ELIZABETH BERRENS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-22-3047	
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO (b) Cancer (Breast) DUE TO (c) Carcinoma lung (massive) Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 170X		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 to 20 Oct , 1967, that (I) (we) last saw the deceased alive on 20 Oct 1967, and that death occurred at 8:10 PM from causes on and on the date stated above.			
22a. SIGNATURE F.B. Whitworth		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) F.B. WHITWORTH, M.D.		22d. ADDRESS 305 WASHINGTON ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 23 10/23/67	
23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City or Town) (County) (State) Westernport Md.	
24. FUNERAL DIRECTOR Westernport, Md.		25a. REC'D BY REGISTRAR OCT 24 1967	
25b. REGISTRAR'S SIGNATURE William J. Judge			

13245

13245

WEST VIRGINIA

ALLEGANY

LEWISBURG

CHIEF OF POLICE

CHIEF OF POLICE

28 GREEN STREET

MEMORIAL HOSPITAL

28

DOUGHERTY

WILKINSON

GENERAL DINE

17

17

17

MORGANTOWN, W.VA.

MORGANTOWN, W.VA.

MORGANTOWN, W.VA.

ELIZABETH BERRENS

JAMES P. WILKINSON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEMORIAL HOSPITAL, CUMBERLAND, MD.

6:10 PM

6:10 PM

6:10 PM

102 W. 11th St., CUMBERLAND, MD.

102 W. 11th St., CUMBERLAND, MD.

102

102

102

102

102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13244

CERTIFICATE OF DEATH

13246

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 8 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG d. STREET ADDRESS RT 1 BOX 151 A e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ARCHIE Middle EARL Last WINTERS			4. DATE OF DEATH Month OCTOBER Day 5 Year 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-1898	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER		10b. KIND OF BUSINESS OR INDUSTRY COAL		11. BIRTHPLACE (County & State, or foreign country) CARLOS, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JAMES WILLIAM WINTERS		
14. MOTHER'S MAIDEN NAME ELIZABETH DENSMORE			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N.A.		
16. SOCIAL SECURITY NO. 214-01-6732			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Carcinoma right lower bronchus DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Fibrosis Metastasis to bone, Anthrosilicosis, Uremia, Coronary Arteriosclerosis.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 30, 1965, 2:25 P.M. to 10/5/67 , that (I) (we) last saw the deceased alive on 10/5/67 19____, and that death occurred at 5/25/67 from causes and on the date stated above.					
22a. SIGNATURE <i>Samuel M. Jacobson</i> 22c. PHYSICIAN'S NAME (Type) SAMUEL M. JACOBSON			22b. DATE SIGNED 10/7/67		
22d. ADDRESS CUMBERLAND, MD.			22e. MED. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 8, 1967		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK	
23d. LOCATION (City or Town) FROSTBURG		23e. (County) MARYLAND		23f. (State)	
24. FUNERAL DIRECTOR <i>Marion M. Sowers</i> MARION M. SOWERS			25a. REC'D BY REGISTRAR OCT 9 1967		
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			25c. REGISTRAR'S NAME CHARLES JUDGE		

13316

CERTIFICATE OF DEATH

13316

DECEASED

DECEASED

TO BE INTERRED

8 DAYS

PROTESTANT

MEMORIAL HOSPITAL

AT 1 BOX 12

WINTERS, E. OCTOBER

ROAD

WHITE

MALE

4-18-1923

CAR

WILLIAM WINTERS

ELIZABETH DEAN

21-08-1923

MEMORIAL HOSPITAL, EMBURY, MD.

(Signature)

Testimony of the family, friends, and neighbors, in the presence of the community, that the deceased was a member of the community, and that the community is in mourning for the loss of the deceased.

Witnessed and attested at the County of Prince George's, State of Maryland, this 21st day of August, 1923.

JOHN W. JACOBSON

JOHN W. JACOBSON

JOHN W. JACOBSON

JOHN W. JACOBSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
13245		CERTIFICATE OF DEATH	
13247			
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN Ib 8/1/1967	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Maryland		d. STREET ADDRESS 95 Ormond St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ALLEGANY COUNTY INFIRMARY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Martha Witchell		4. DATE OF DEATH Month October Day 1 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/14/1886
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mr. Henry Filer		14. MOTHER'S MAIDEN NAME Martha Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N.A.		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT P.O. Box 599 Cumberland, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal insufficiency DUE TO Chc A.S.H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) many years (c) Arterio-sclerosis many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Switz Sarantiaz		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/1/1967 , 19____, to 10/1/1967 , that (I) (we) last saw the deceased alive on 10/1/1967 , and that death occurred at 1:12 P.M. 8-57 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. John Topper		22b. DATE SIGNED 10 / 2 / 1967	
22c. PHYSICIAN'S NAME (Type) Dr. John Topper		22d. ADDRESS Memorial Hospital Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION (City or Town) (County) (State) Frostburg, Allegany, Md.	
24. FUNERAL DIRECTOR Marion M. Sowers		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE OCT 5 1967	

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13246

13248

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital--DOA			d. STREET ADDRESS Route 4, Oldtown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Linda Middle Jean Last Woods			4. DATE OF DEATH Month Oct. Day 17 Year 1967		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 28, 1957		9. AGE (In years last birthday) yrs. 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Elementery School		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
13. FATHER'S NAME Charles C. Woods			14. MOTHER'S MAIDEN NAME Eleanor Whitaker		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mother Mrs. Eleanor Woods, Rt. 4, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XXXX DUE TO X (c) (Ran into side of Automobile)					INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran into side of moving vehicle			
20c. TIME OF INJURY Month, Day, Year 3:55 p.m. Oct. 16 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Rt. 51 0.2 miles East Cumberland, All. Md.	
20f. (City or town) (County) (State) Cumberland, Md. Allegany					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarellic		M.D. BENEDICT SKITARELIC, M.D.		22. DATE SIGNED October 16, 1967 Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 19, 1967		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE OCT 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

13245

Allegany

Quadrant

Memorial Hospital--DCA

2 years

Compendium

Robert L. Galt, Jr.

Index

Female white

Student

Secretary, Church

Allegany

John C. Galt

none

Rev. Eleanor Galt, Jr., D.D., D.D., D.D.

Presbyterian (Evangelical) Church

Organized Church

(For information of interested parties)

See index also for other vehicles

Oct. 10, 1957

XX

XX

HEATON, S. L. W.

XX October 10, 1957

Oct. 1, 1957

trial

James L. Galt, Jr., D.D., D.D., D.D.